RARE FORMS OF GOUT AND RHEUMATISM

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MR. PRESIDENT AND GENTLEMEN: This I consider "a red-letter day" in my professional life's work, and more particularly from the very fact of having received so generous an invitation, through the secretary of your Association, to read a paper on this auspicious occasion. We Canadians, as a whole, delight in noting the advance of our American neighbours in almost every line of thought in medical and surgical science. The assembled wisdom of this Association from the state of New York, almost a kingdom in itself, is only an index to the intellectual power to-day at work in almost every state of your prosperous Republic. How gratifying it must be to con over such names as Rush, Mott, McDowell, Sims, Gross, Pancoast, Flint, Sayer, Thomas, Emmett, DaCosta, Bowditch, Godell, Pepper, Weir-Mitchell, Bull, McBurney, and a host of others, equally great but too numerous to mention, who by their skill and ability have added lustre to the name of America. To-day I propose offering some observations on rare forms of gout and rheumatism, conditions not by any means frequent, as to their occurrence.

CASE I.—PNEUMONIC GOUT.—The following brief notes are of a pneumonic form of gout, associated with slight hepatic complication. H. V., seventy-eight years of age; stout habit of body; not plethoric, but generally vigourous, and accustomed to long hours of arduous official duty; cannot trace gout to his ancestors, and always lived well and liberally. February 10, 1893, suddenly seized with acute pain in the right side of chest, opposite the middle lobe of lung, with general malaise and rather severe cough; no excessive flushes in the cheeks; the breathing was somewhat hurried, about thirty per minute; temperature, 101.5° to 103° F., and the pulse ranged from 100 to 114. The cough, after the

first day, was associated with the expectoration of a thick, tenacious, and rusty-coloured mucus, not uniform, however, in its character, but somewhat patchy as to the distribution of the blood through the tough sputum. The left side moved more freely during the respiratory process than the right, and over and about the seat of pain in the right side there was an evident area of dulness on percussion, and yet the breath sounds were heard with a degree of almost unexpected clearness, with an occasional slight mucous râle. The posterior aspect of the right lung held its ground, kept moderately clear, and in fact the pulmonic trouble was chiefly confined to the lateral and anterior aspect, middle lobe, right lung. Throughout, the sputa presented an unusually tenacious character, and up to February 21 exhibited a patchy, rusty, and most peculiar appearance, after which date it became clear, but retained the sticky, glutinous peculiarity up to February 27, when it subsided. During the entire illness the pain in the side was not of the usual pleuritic type, but more of a burning, throbbing, aching, and piercing pain, and out of all proportion to the ordinary defined pulmonic condition. From his well-known gouty diathesis, I was led to believe the attack was really one gouty in character, and informed the friends that metastasis to the feet of the lung condition was not unlikely. On February 22, both feet became very painful and swollen,—a condition of system (as to his feet) he had experienced several times during the past ten years. Almost immediately the lung improved in every particular, which quite settled the point as to the gouty character of this attack in the lung tissue as a primary development. Throughout, the usual course of treatment was adopted, with the free use of elixir salicylate of lithia, and lithia water as well. During the entire attack I saw no special indications of hepatic trouble, beyond a degree of uneasiness about the liver generally. Four years ago he had a well defined attack of jaundice, unattended by anatomical lesion to account for its development; it was of short duration, and passed off quickly.

Case II.—Perityphlitic Gout.—The same individual whose case I have just cited was the subject of the following data: September 10, 1892, aged seventy-seven years. Almost up to the present attack had been enjoying apparently good health; retired to bed this same evening, and in the middle of the night was suddenly seized with a severe pain in and about the region of the appendix vermiformis, attended with a sensation of throbbing, together with a degree of tension in this particular region, which radiated more or less over the entire abdominal walls; considerable heat of skin, with a degree of restlessness, general febrile disturbance, and a sense of uneasiness about the stomach, with occasional vomiting. Temperature, 102° F.; pulse, 116, full and regular. The pain and sensibility of the abdominal wall, chiefly over the ileo-caecal region. The bowels were constipated and the tongue moderately coated with a moist white fur, pointing to evident gastric derangement for a few days. Knowing the gouty history of this patient for some years, although not of an hereditary type, I suspected, from the character of the pain, boring and gnawing, such as I had observed more than once in his feet,

that it might prove a case of gout, of which there were well defined results, such as tissue thickening about the tarsus and heels of both feet, owing to the deposition of gouty material during past years. The fingers in both hands showed also evidences of disturbed chemistry in the system, resulting in gouty thickening in and about various joints. The bowels, though at once relieved by an enema, still continued painful. Linseed poultices were freely applied, sprinkled with chloroform liniment, and tablets of sulphate of morphia freely administered, to relieve the intense suffering, which was so acute as to almost prohibit the most moderate bed-clothing. Salicylate of lithia and lithia water were freely given, as soon as admissible, and the bowels were frequently washed out with warm water, which almost played the part of an internal poultice. The pulse and temperature continued high for fully five days, when both gradually lessened in intensity, and about the sixth day pain was complained of in both feet, particularly about the toes, but not by any means as severe as in the marked metastasis after the attack of pneumonic gout.

At this date there was a marked amelioration in the entire character of the symptoms, the abdomen became more flaccid and much less painful on pressure, and the decidedly caky area in the ileo-caecal region gradually parted with its suspicious indications. McBurney's appendix point was for days an interesting and instructive lookout, until rendered less attractive by the evident outcome of metastatic gouty action. Undoubtedly there was well marked and circumscribed induration in the ileo-caecal area. The precise condition or character of this induration was difficult to define, and yet the rapid change consequent on metastatic action pointed to gouty deposition in or about the region of the appendix, so peculiar and transitory in its manifestations. At the end of three weeks an excellent recovery was made, and since that date there has been no recurrence of intestinal trouble.

CASE III.—RHEUMATIC PERITYPHLITIS.—Miss T., twelve years of age, vigourous and robust habit of body, conformation regular, and organs, as a whole, normal prior to the present attack. Of a highly nervous temperament, but usually enjoyed excellent health and spirits. June 1, 1893, complained of pain and sense of uneasiness in her feet, with a general feeling of systemic irritability. June 3, was suddenly seized with severe pain in the bowels, but more particularly in and about the ileo-caecal region, where tenderness on pressure was most marked. Fully two days prior to June 1, a sense of heat and feverishness was experienced, and prior to being under my charge. Temperature, 102.5° F., and pulse, 120. The bowels were at once washed out by a warm-water enema, which afforded much relief. Hot linseed poultices applied, and placed on milk diet and an aconite mixture. From June 2 to 8 the pain experienced over the bowels was very considerable, and the tenderness so severe that coughing or stretching of the legs increased the pain in a most marked manner. Turpentine enemata also afforded considerable relief. June 4, there was a decided hardness on moderate pressure over the ileo-caecal region, which gave one the

impression that some tissue change had taken place, and the fact that rigidity in the abdominal walls was more marked on the affected side than on the other led me to view the condition with a degree of suspicion, although the actual position of hardness was a little lower down than McBurney's point. For fully three days the temperature was over 102° F., on which account suppuration would not be an unlikely result. June 7, the right shoulder, elbow, and wrist joints exhibited well defined symptoms of acute articular rheumatism, these parts being painfully pressure swollen, and moved with difficulty. Just in proportion as these almost outside rheumatic conditions developed, the abdominal symptoms actually lessened in intensity, and on the 10th the entire features of the case evidenced a marked change for the better, no relapse being experienced whatever.

The question very naturally arises, What was the attack, and how developed? True, the recognition of appendicitis is not all that is needed.

In this case, almost from the first, there was a localised pain, associated with tenderness over the region of the right iliac fossa and ascending colon, with well defined swelling, and for days the pain was so severe that it was increased at once by coughing or deep inspiration, and the almost constant desire was to elevate both knees to relieve suffering. For days, also, there was entire inability to take nourishment, owing to attacks of vomiting. The bowels were frequently injected with warm linseed tea, which afforded a degree of nourishment as well as a clearing of the contents from the canal.

In this case I concluded there was lodgment of undigested material in the caecum, and most likely induced by inability to assimilate the food, owing to deflected nerve-power from over-mental strain, as is frequently the case in our schools and universities at the present day. In the ordinary avocations of life we can trace the operation of like results, interfering seriously with the very principles of sanguinification and blood change.

The next question is, How is rheumatism associated with perityphlitis? True, the essential cause of rheumatism is still a doubted point. Errors in diet, as an aetiological factor, have much to do with the production of both gout and rheu-

matism, and such strengthen the metabolic theory, that rheumatism depends on a morbific material produced within the system, the result of defective processes of assimilation. True, Prout, Latham, Richardson, Mitchell, and Dr. William H. Porter, of New York, have thrown much light on the subject of rheumatism, and certainly the present case points to rheumatic complication as the outcome of defective assimilation, an important factor in its production. Thus the chemical laboratory of the human system becomes disturbed, resulting in false products, enabling us to establish a connecting link between even perityphlitis and rheumatism. In the structure of the intestinal walls there is undoubtedly a large amount of fibrous tissue, just as in the fascia and tendons of the joints, and it is reasonable to suppose that these structures should be influenced in the same manner; and assuming that the case under consideration was even quasi-rheumatic in its character, it affords one more illustration as to the importance of giving due consideration to the line of action embraced in medical and surgical treatment under like circumstances.

In a recent paper by A. Haig, M. A., M. D., Metropolitan hospital, London, on gout of the intestines, he states, that his chemical and experimental experience has led him to believe that "a very large number of cases of colic, enteralgia, and enteritis, and cases which are clinically indistinguishable from typhlitis, are neither more nor less than a gout of the walls of the intestinal tube, or a rheumatism," as has just been defined. In Canada, as a whole, gout is almost an unknown quantity, except in occasional cases of an hereditary type. Our people, in the midst of life's pursuits, live in a moderate way, which contributes greatly to the promotion of health. On the other hand, rheumatism is of frequent occurrence. The coldness of our winter climate, the occasional absence of flannel, and excessive exposure contribute to develop rheumatism. After noting the life-history of many thousands of our "lumbermen," I have been amazed at the

few attacked by rheumatism. Bread, pork, and strong tea constitute their chief articles of diet, and the general experience is, that the tea enables them to digest the pork with remarkable comfort; and certainly, after a hard winter's work, they return home well nourished and healthy in every particular.

These facts point to simplicity as to diet. Our progenitors frequently attained the age of "three score and ten," nourished by grain ground between two stones. As a rule, the people of the present generation live too fast, resulting in mental strain and the absence of simplicity. With greater attention to diet, which should be simple in its character, in conformity with the normal functions of the alimentary canal, and the avoidance of alcoholic beverages as a whole, I feel confident perityphlitic and appendix troubles, even unconnected with gout and rheumatism, would become less troublesome factors in the line of disease. To avert various irregularities in the alimentary canal, which, if neglected, will undoubtedly lead to trouble in time, is as important as subsequent treatment, when the stage is passed in which the efforts of nature are powerful to afford relief. What active agent in the system is more frequently tampered with than gastric juice, which requires a normal temperature to perform its part in the economy? Ice-water at the commencement, and ice-cream at the end, of a meal, may be fashionable, but certainly not life preserving. Unassimilated food makes its way to parts not designed by nature to transform and absorb. As the result, how frequently, on percussion, we find extensive portions of bowel ballooned by abnormal efforts to accomplish the digestive process. Such conditions result from irregularities in living. No portion of the alimentary canal is more liable to diseased manifestations than in and about the appendix, which is a species of loop line to the digestive tract.

Insurance associations cannot note too carefully the probabilities of life in this connection. There is still much to be

accomplished, and let our medical education be so directed as to bring about simplicity in living, as near as possible, to the normal functions of our organs, and our generation will be greatly benefited.